- AN INDIVIDUALIZED TRANSITION PLAN (ITP) will be completed prior to all moves associated with transitions from nursing facility/institutional settings to community settings.

- The ITP is completed after the MFP participant signs the *MFP Informed Consent*. Person-directed planning is undertaken to complete the ITP. Person-directed planning meetings include the MFP participant, family members, friends, care givers, guardian (if applicable), the MDSQ Options Counselor (MDSQ OC) and/or MFP Transition Coordinator (MFP TC), the nursing facility/institutional discharge planner, and/or waiver case manager, care coordinator, support broker and other appropriate facility staff.

- The MFP facilitator (MDSQ OC, MFP TC) is responsible for facilitating Person-Centered Planning and the subsequent development and writing of the ITP, including the documentation in the plan and monitoring the outcomes. A complete ITP includes the participant's goals/desired outcomes, choices of living arrangements, preferences, strengths, barriers to transition, MFP Service needs in Part A, Waiver Service needs in Part B and State Plan Services in Part C.

- The MFP facilitator will distribute a copy of the ITP showing specific transition assignments to all persons having an assignment to complete. The ITP is distributed prior to discharge to assure timely implementation.

- The MFP participant, friends, family members and appropriate transition planning members receive a copy of the ITP.

- The Department of Community Health (DCH), MFP Office receives a copy of the completed ITP within three (3) business days of completion.

- The entire transition team reviews the ITP two to four weeks before the discharge date from the nursing facility/institution. The MFP facilitator updates the ITP with any changes in status. Updates to the ITP are documented and DCH/MFP office receives a copy of the updated ITP within three (3) business days of the completed update.

Guidelines and examples for completing the ITP:

1. Enter the requested participant information. Enter the requested facility name and location. Enter the date the ITP was prepared. Check the appropriate box for the stage of the ITP (initial or updated). Enter the type of qualified residence/living arrangement the participant desires to enter. Enter the MFP facilitator's name and contact information.

2. Enter the projected discharge/move out date and actual discharge/move out date.

3. Housing Choice/Living Arrangement: Include qualified residence preference with priority and type of living arrangement (i.e. quieter environment; closer to friends and

family; opportunity for greater independence in activities of daily living; family setting; person/friends/family assistance, access to public transit and paratransit, access to community services, healthcare services, pharmacy and shopping and entertainment). The TC facilitates a discussion of potential qualified residence types and living arrangements.

4. Housing – Identify problems/issues and strategies for addressing and resolving housing-related problems/issues. The MFP participant may have lived for several months or years at the facility and may need assistance with independent living skills, budgeting, problem solving, searching for housing, locating transportation, locating a pharmacy, a personal care physician, shopping, social and recreation activities in the community. The person might be leaving a close friend behind or might want to join a roommate in a community. A MFP peer supporter can assist the participant to do a housing search and look at housing options. The housing search process is also a great time to work out community transportation issues. Unpaid utility bills and other budget issues are discussed.

5. Personal Goals/Desired Outcomes from Transition: Conduct Person-Centered Planning sessions with the transition team/circle of support. Based on the results of Person-Centered Planning, list the participant's short-term and long-range goals. Describe the participant's personal assets/strengths. List barriers to resettlement identified by the participant, family and transition team. List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to assist the person to remove listed barriers. The MFP participant will need to be introduced to older adults and/or persons with similar disabilities living successfully in the community. In this section, include transition activities to assist the person in adjusting to resettlement. For example, if separating from a close friend, there may need to be a plan for the person to make contact with the friend either by phone of by personal visit, or by email/mail, etc. Such an approach recognizes the importance of the MFP participant's existing support network while assisting the person to make new relationships in the community.

6. Health/Nutrition Goals: List health and nutrition goals; recommended medical follow-up; allergies; current medications/dosages, self-administration of meds; lifting/positioning needs; type of diet; dietary restrictions (food allergies, low cholesterol etc.); food intake/preferences; food preparation strategies and dietary restrictions. List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to assist the person to achieve goals.

7. 24/7 Emergency Backup Plan: identify risks to the MFP participant's health, welfare and safety based on resettlement choice of residence type. For each identified risk to health and safety in the preferred community living environment, develop an individualized contingency plan for emergency back-up. The ITP must include plans for equipment failures, transportation failures, natural disasters, power outages and interruptions in routine care. This information should be gathered and put into a notebook (or something similar) so that the participant will be able to access it in time of emergency. In the notebook or similar, provide the participant with 24/7 emergency phone contacts for case manager and/or care coordinator and service providers. Vendors/agencies are required to

provide 24/7 backup for direct care staff and to instruct direct care staff on participant needs and preferences. MFP participants using participant-directed options must identify at least two individuals (i.e. friends, family members, etc) in their emergency plans to assist them in the event that routine care staff doesn't show up.

8. Vision/Hearing/Dental/Mobility Goals: List vision, hearing and personal mobility goals of the participant, and the impact of current functioning on activities of daily living (ADLs); list need for visual exam, prescription glasses, dental exam/cleaning/dental work, hearing assessment, hearing aid, durable medical equipment for mobility that the participant is currently using or that is needed to maximize current functioning. List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available (i.e. FODAC) to assist the participant to achieve vision, hearing, dental and personal mobility goals for independence. If this area does not apply to the participant, check the N/A checkbox.

9. Communication Goals: List the communication goals of the participant, the methods that participant uses to communicate (verbal, non-verbal, uses gestures, communication board, AAC device, assistive telephone technology, TTY, etc.); any specific signals a person may give to communicate (ex. "whine" means doesn't feel well; "hand to head" means headache, etc.). List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to assist the person to achieve communication goals. If this area does not apply to the participant, check the N/A checkbox.

10. Social/Recreational Goals: List the participant's leisure and recreation interests/preferences and goals. List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to assist the person to achieve social and recreational goals. If this area does not apply to the participant, check the N/A checkbox.

11. Self Care (Domestic and Personal) Goals: List the participant's self care routines, goals, interest in self-directing personal services and supports, the degree of personal independence; amount/type of assistance needed for activities of daily living in personal care (eating, dressing, hygiene, etc.); and domestic skills (meal preparation, laundry, budgeting, etc.). List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to assist the person to achieve self care goals, including self-direction of personal services and supports. If this area does not apply to the participant, check the N/A checkbox.

12. Assistive Technology (AT) and/or Durable Medical Equipment (DME) Use and Needs: What assistive technology devices and DME is the participant currently using to maintain the current level of functioning? What is the availability of the devices/DME? Will DME and AT devices move with the person or will they need to be procured using MFP funds and/or Medicaid for DME? Has the participant with complex rehabilitation technology needs been referred to an appropriate wheelchair/seating clinic for assessment? List personal assets/strengths, resources offered by friends and family, MFP/waiver/state plan

services and community programs and services available to assist the person with assistive technology (including *Tools for Life and/or FODAC* resources) and DME equipment and supply needs and vendor/suppler for each. If this area does not apply to the participant, check the N/A checkbox.

13. Community Access Goals: List the independent living community skills, strengths or degree of independence in use of money to purchase services; travel; use of community facilities and services; basic safety awareness/skills. Identify the community services that the participant will most likely benefit from and any barriers to obtaining these services. List personal assets/strengths, resources offered by friends and family, MFP/waiver services and community programs and services available to assist the person to achieve higher degrees of independent living community skills.

14. Employment Goals: list pre-vocational, supported-employment and/or competitive or customized employment goals, interests, skills, and attitudes; list type of work experience and career interests; list barriers and resources to gainful employment. List personal assets/strengths, resources offered by friends and family, MFP Supportive Employment Evaluation services and supported employment waiver services along with community programs and services available to assist the person to achieve employment goals. If this area does not apply to the participant, check the N/A checkbox.

15. Transportation Needs and Barriers to Access: List the transportation needs the participant may have. Is accessible public transit and/or para-transit available/needed? Is travel training needed? Is a wheelchair accessible personal van needed, does the person need someone to ride with her/him or is the participant independent? List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to assist the person to achieve independent transportation goals. If this area does not apply, check N/A checkbox.

16. Financial Goals: Are the appropriate people aware of and familiar with the SSI/SSDI /SS retirement transfer issues and the involvement DCH MFP in Atlanta? The DCH MFP will terminate the institutional enrollment and change the participant's eligibility status from institutional to community Medicaid. Are there any outstanding financial issues? What about unpaid utility bills? If unpaid utility bills from the past are preventing the person from transitioning, consult with the county DFCS office for programs to assist the participant to pay off these old utility bills. List the participant's financial goals. List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to resolve financial issues and achieve financial goals. Assist the person to develop a budget for community living (see #22 Income and Resources-Budget for Community Living). Establish how the MFP participant will pay for rent, utilities, food, transportation, medicines, recreation, etc.

17. Legal Issues: Are there legal issues to consider? List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to assist the person to resolve these legal issues. If this area does not apply to the participant, check the N/A checkbox.

18. Family/Guardian Involvement Issues: Who is involved and what is the relationship? How often does contact occur; type of contact (phone calls, visits, etc.); person's response to interaction with family/guardian. Does the participant want to terminate guardianship? List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to assist the person to resolve family/guardian involvement issues. If this area does not apply, check the N/A checkbox.

19. Part A: MFP Pre- and Post-Transition Services: List the MFP Pre-and Post-Transition Services selected by the participant/team in the Table provided. Under "Rationale" provide the justification for each service selected. Why is the services needed? How will it be used to support successful living in the community? How much will it cost? Are the costs within the maximum allowed for the service? The participant initials each MFP service selected.

20. Transition Plan/Assignments: Identify pre/post-discharge or follow-up activities that need to occur for a smooth transition and continuity of care and services. Include specific names of persons (when possible) that are assigned to implement the ITP.

21. Follow-up Plan: Specify what follow-up is to be given, when and by whom.

22. Income and Resources-Budget for community living: Based on the information obtained about the participant's Income and Resources from the MFP Screening Form, discuss and develop a budget for community living with the transition team. Use the space provided to develop a preliminary community living budget.

23. Part B Waiver Services: Using the table provided, identify generic waiver services provided under the waiver. Under "Rationale" describe how the waiver services will work with MFP services to support the participant in the community. Why is the services needed? How will it be used? If this area does not apply, check the N/A checkbox.

24. Part C Other Services: Using the table provided, identify State Plan and/or Other Services selected by the participant and the team. Under "Rationale" describe how State Plan and/or Other Services will work with MFP services to support the participant in the community. Why is the services needed? How will it be used? If this area does not apply to the participant, check the N/A checkbox.

25. ITP Signature Page: Each member of the transition team signs the signature page.

Note: the participant's learning style/preferences (what works best with this participant) should be incorporated in each domain as applicable. **Note to TCs: Send the completed ITP to the DCH/MFP Office via File Transfer Protocol.**